

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 08891 #163

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Cabret
 City or town P. Frederick, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cabret Co. Hospital
 How long in hospital or institution? 1 day

3. (a) FULL NAME

Vincent Accardy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWM

6. (b) Name of husband or wife

Margaret Accardy

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 22, 1883

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Italy

(Town, county and state)

10. Usual occupation

Machinist

11. Industry or business

Vitto Accardy

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Margaret Accardy

Address

North Beach Park

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 8, 1947
(month) (day) (year)

(Cemetery or crematory)

Congressional Cem.

Location

Wash. D. C.

18. Funeral director

D. A. Hawkins & Son

Address

Mutual, Md

19. Date rec'd by registrar

10/7

1947

T. Keward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty CabretCity or town North Beach Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

?

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 5, 1947 at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

10/4 1947 to 10/5 1947and that I last saw him alive on 10/4

1947

Immediate cause of death

the myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Huntingtown Date signed 10/7/47

RECEIVED

OCT 8 1947

BUREAU OF

cont'd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

08892

Reg. Dist. No. 51

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Columbia

City or town.....

Pt. Fred.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Baby Sib Brodeur

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*F**W**single*

6.(b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

6.(c) If alive, give age..... years

28 Oct 47

8. AGE:

Years

Months

Days

If less than one day

7 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19

Date

Year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Md Col

City or town.....

St. Leonard's

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

28 Oct

1947

at *11:30* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 Oct

1947

to *28 Oct*

1947

and that I last saw her alive on *28 Oct*

1947

1947

Immediate cause of death

One month

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hermann

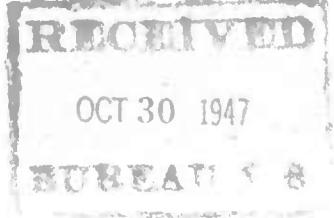
M. D. or other

Address

Havelburg

Date signed

10/29/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

088508
Reg. Dist. No.

1. PLACE OF DEATH:

County

Carroll
Buxby, Md

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laura A. Lowell

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

J. Benjamin Lowell

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Jan. 24, 1867

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Carroll County, Md

(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

John C. Chambers

12. Name

Mother FATHER

13. Birthplace

Md.

14. Maiden name

Margaret Ogden

15. Birthplace

Md.

16. Informant

Mrs. H. B. Dremmond

Address

Buxby, Md

17. Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

Date thereof Oct. 5, 1947

(month) (day) (year)

(Burial, cremation, or removal. Which?)

St. Pauls

Buxby, Md

A. O. Hawkins & Son

Montgomery, Md

J. J. Dillane

Oct 5 - 1947

J. J. Dillane

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Carroll

City or town

Buxby

(If outside city or town limits, write RURAL and give nearest town)

Street No.

20

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

820

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 2, 1947 at 1:45 P.M.

21. IDENTIFY that death occurred on the date above stated; that attended deceased from

Sept. 25 1947 to Oct. 2 1947

and that I last saw h alive on Oct. 2 1947

Immediate cause of death

Coronary occlusion

Due to

Due to

Hypertension c.v.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or

Address

Oct 3, 1947

Date signed



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is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08894 #164

61

Reg. Dist. No.

51

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County CabinetCity or town Broomes Island

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Carl Halley

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MWM

6.(b) Name of husband or wife

Tillie Halley6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

Oct. 17, 1880

8. AGE:

Years

Months

Days

If less than one day

661121

hrs.

min.

9. Birthplace

Charles Co., Md.

(Town, county, and state)

10. Usual occupation

Stationary Engineer

11. Industry or business

Zachary Halley

12. Name

Mother

Father

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date

of

Year

Date thereof Oct. 11, 1947
(month) (day) (year)Cedar Hill CemeteryWashington, D. C.G. O. Haakman & SonMutual, Md.2d Award

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State mdCounty CabinetCity or town Broomes Island

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number

577-07-3125

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw h.....alive on 19.....

Immediate cause of death

Cerebral HemorrhageDue to Hypertension
+ Diabetes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gage J. Stitt

M. D. or other

Address James Murch Date signed Oct 10 1947



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The copy of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08895

93d

Reg. Dist. No.

58

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Calvert

City or town

Appt. Calvert

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie Oliver

4. Sex

F

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov 5, 1883

8. AGE:

64

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

John Johnson

13. Birthplace

Md.

14. Maiden name

Jane Bishop

15. Birthplace

Md

16. Informant

Annie Gross

Address

Lusby Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-12-47
(month) (day) (year)

Cemetery or crematory

St. Johns

Location

Calvert

18. Funeral director

P. E. Sewell

Address

Prince Frederick, MD

19. Date rec'd by registrar

Oct 12- 1947

19

47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Appt. Calvert, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-12-47 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 8 to Oct 18, 1947, to,

and that I last saw her alive on Oct 10, 1947.

Immediate cause of death

Central hemorrhage

Due to

Hypertension C.V.L.

Due to

Other conditions Generalized arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rd Villareal M. D. or other

St. Leonard, MD Date signed Oct 12, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08896
940

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Dunkirk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

3. (a) FULL NAME

Elsie Lucy Trott

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife.....

Clinton Trott

7. Birth date of deceased (mo., day, yr.)

Sept 28 1886

years

8. AGE: Years

61

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Dunkirk Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

FATHER

12. Name.....

Robert Whittington

13. Birthplace

Md

MOTHER

14. Maiden name.....

Emma Childs

15. Birthplace

Md

16. Informant.....

Mrs Lucy Whittington

Address

Dunkirk, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Oct 24 47

(month) (day) (year)

Cemetery or crematory.....

Smithville Cem.

Location.....

Dunkirk, Md

18. Funeral director.....

W H Hatchins

Address

Anseigo, Md

19. Date rec'd by registrar

Oct 24 1947

(Date rec'd by registrar)

Grace L Hatchins

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Calvert

City or town.....

Dunkirk

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 22

1947

at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Coronary Thrombosis

DURATION

Due to.....

Atherosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

H. Ferguson

M. D. or other

Address.....

Hedgesburg

Date signed

Oct 24 1947

